TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MEMORIAL COMPOUNDING PHARMACY

Respondent Name
AMERICAN ZURICH INSURANCE COMPANY

MFDR Tracking Number
M4-17-1521-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 23, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached bills have been denied by the carrier stating no preauthorization. . . . We are now requesting Medical Fee Dispute Resolution."

Amount in Dispute: $1,453.22

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 16, 2016 to June 29, 2016	Pharmacy services – compound drugs dispensed	$1,453.22	$1,453.22

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 defines terms related to medical billing and processing.
3. 28 Texas Administrative Code §133.240 sets out procedures for medical bill payments and denials.
4. 28 Texas Administrative Code §134.502 sets out provisions regarding pharmaceutical benefits.
5. 28 Texas Administrative Code §134.503 sets out the pharmacy fee guideline.
6. 28 Texas Administrative Code §134.600 sets out requirements regarding preauthorization.

7. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, receipt acknowledged January 31, 2017. Per Rule §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier has not responded. Accordingly, this decision is based on the information available at the time of review.
8. The insurance carrier denied the disputed services with claim adjustment reason code:
    - 39 – Services denied at the time authorization/pre-certification was requested.

Issues

1. Did the workers' compensation insurance carrier respond to the request for medical fee dispute resolution?
2. Are the insurance carrier's denial reasons supported?
3. What is the recommended reimbursement for the disputed pharmacy services?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier's Austin representative, Flahive, Ogden & Latson, acknowledged receipt of the MFDR request on behalf of the insurance carrier, Zurich, on January 31, 2017.

    28 Texas Administrative Code §133.307(d) requires that "responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division."

    Rule §133.307(d)(1) further requires that "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile **within 14 calendar days** after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

    As of the date of this review, the division has not received any response information from the insurance carrier. The division concludes the respondent has failed to meet the requirements of Rule §133.307(d)(1). Consequently, this decision is based on the information available at the time of review.

2. The insurance carrier denied disputed services with claim adjustment reason code 39 – "Services denied at the time authorization/pre-certification was requested."

    The insurance carrier did not provide any documentation to support that authorization/pre-certification had been requested or denied. No documentation of prospective utilization review was presented or documentation to support that an adverse determination had been issued in accordance with the requirements of Rules §133.240(q), §134.502(g), and §134.600.

    28 Texas Administrative Code §134.530(b)(1)(B) states that for compounded drugs, preauthorization is only required for "any compound that contains a drug identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates"

    Review of the submitted pharmacy bills finds no drugs identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary.

    Consequently, the division finds that preauthorization was not required for the disputed prescription drug compounds and the insurance carrier has failed to support its denial reasons. The disputed items will therefore be considered for reimbursement according to applicable division rules and fee guidelines.

3. The disputed pharmacy services involve the dispensing of prescription drugs with reimbursement subject to 28 Texas Administrative Code §134.503(c), which requires that:

   The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:

   (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
      (A) Generic drugs: ((AWP per unit) × (number of units) × 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;
      (B) Brand name drugs: ((AWP per unit) × (number of units) × 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;
      (C) When compounding, a single compounding fee of $15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection; or

   (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
      (A) health care provider; or
      (B) pharmacy processing agent only if the health care provider has not previously billed the insurance carrier for the prescription drug and the pharmacy processing agent is billing on behalf of the health care provider. The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately as required by 28 Texas Administrative Code §134.502 (d)(2).

   Reimbursement for the disputed prescription drugs is calculated as follows:

   Compound dispensed June 16, 2016

Ingredient(s)	NDC & Type	Unit Price	Units	AWP Formula §134.503(c)(1)	Billed Amount §134.503(c)(2)	Lesser of (c)(1) or (c)(2)
VERSAPRO	38779252903 Brand	$3.20	45	($3.20 × 45.02) × 1.09 = $157.03	$144.06	$144.06
MELOXICAM	38779274601 Generic	$194.67	0.2	($194.67 × 0.18) × 1.25 = $43.80	$35.04	$35.04
FLURBIPROFEN	38779036209 Generic	$36.58	5	($36.58 × 5) × 1.25 = $228.63	$175.58	$175.58
BUPIVACAINE HCL	38779052405 Generic	$45.60	1.2	($45.60 × 1.2) × 1.25 = $68.40	$54.72	$54.72
ETHOXY DIGLYCOL	38779190301 Generic	$0.34	3	($0.34 × 3) × 1.25 = $1.28	$1.02	$1.02
TRAMADOL HCL	38779237409 Generic	$36.30	6	($36.30 × 6) × 1.25 = $272.25	$217.80	$217.80
CYCLOBENZAPRINE HCL	38779039509 Generic	$46.33	2	($46.33 × 2) × 1.25 = $115.83	$83.39	$83.39
		Total Units:	62.4		Subtotal:	$711.61
					+ $15 compound fee = **Total**:	$726.61

   Compound dispensed June 29, 2016

Ingredient(s)	NDC & Type	Unit Price	Units	AWP Formula §134.503(c)(1)	Billed Amount §134.503(c)(2)	Lesser of (c)(1) or (c)(2)
VERSAPRO	38779252903 Brand	$3.20	45	($3.20 × 45.02) × 1.09 = $157.03	$144.06	$144.06
ETHOXY DIGLYCOL	38779190301 Generic	$0.34	3	($0.34 × 3) × 1.25 = $1.28	$1.02	$1.02
BUPIVACAINE HCL	38779052405 Generic	$45.60	1.2	($45.60 × 1.2) × 1.25 = $68.40	$54.72	$54.72
CYCLOBENZAPRINE HCL	38779039509 Generic	$46.33	1.8	($46.33 × 1.8) × 1.25 = $104.25	$83.39	$83.39
TRAMADOL HCL	38779237409 Generic	$36.30	6	($36.30 × 6) × 1.25 = $272.25	$217.80	$217.80
FLURBIPROFEN	38779036209 Generic	$36.58	4.8	($36.58 × 4.8) × 1.25 = $219.48	$175.58	$175.58
MELOXICAM	38779274601 Generic	$194.67	0.2	($194.67 × 0.18) × 1.25 = $43.80	$35.04	$35.04
		Total Units:	62		Subtotal:	$711.61
					+ $15 compound fee = **Total**:	$726.61

4. The maximum allowable reimbursement is $1,453.22. The insurance carrier has paid $0.00, leaving an amount due to the requestor of $1,453.22. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The Division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,453.22.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $1,453.22, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	April 7, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.